



LOS ANGELES COUNTY COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES January 21, 2014

Approved
1/20/2015

P&P MEMBERS PRESENT	P&P MEMBERS PRESENT, CONT.	PUBLIC	COMM STAFF/ CONSULTANTS
Al Ballesteros, MBA, <i>Co-Chair</i>	Carlos Vega-Matos, MPA	Kevin Donnelly	Craig Vincent-Jones
Bradley Land, <i>Co-Chair</i>		Miguel Fernandez	
Michelle Enfield		Susan Forrest	
Sharon Holloway	P&P MEMBERS ABSENT	Joseph Green	DHSP STAFF
Michael Johnson	Lynnea Garbutt	Anthony Gutierrez, MA	None
Abad Lopez	Monique Tula	Miki Jackson	
Marc McMillin		David Kelly	
Juan Rivera/Rev. Alejandro Escoto, MA		Douglas Lantis	
Ricky Rosales		Rob Lester	
LaShonda Spencer, MD		Scott Singer	

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- 1) **Agenda:** Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, 1/21/2014
- 2) **Table:** Planning, Priorities & Allocations (PP&A) Committee Member "Conflicts-of-Interest", 1/21/2014
- 3) **Minutes:** Planning, Priorities & Allocations (PP&A) Committee Minutes, 10/22/2013
- 4) **Minutes:** Planning, Priorities & Allocations (PP&A) Committee Minutes, 11/19/2013
- 5) **Minutes:** Planning, Priorities & Allocations (PP&A) Committee Minutes, 12/17/2013
- 6) **Memorandum:** FY 2014 Ryan White Parts A/B and MAI Allocations, 6/13/2013

1. CALL TO ORDER:

- Mr. Land called the meeting to order at 12:00 noon and attendees declared their conflicts.
- Mr. Vega-Matos noted the JWCH Case Management, Non-Medical service category listing has been replaced by Medical Care Coordination and the APLA Health and Wellness listing for Referral actually should be for HIV Outreach.
- DHSP will shortly provide conflicts information for prevention and STD contracts. Mr. Vincent-Jones said the current list was developed from DHSP information. Prevention and STD conflicts will be needed once PP&A begins to address those areas.
- ➡ Update "Conflicts-of Interest" list as noted.

2. APPROVAL OF AGENDA:

MOTION #1: Approve the Agenda Order with Item 7 deleted (***Passed by Consensus***).

3. APPROVAL OF MEETING MINUTES:

MOTION #2: Approve the meeting minutes, as presented, from the Planning, Priorities and Allocations (PP&A) Committee meetings of 10/22/2013, 11/19/2013 and 12/17/2013 (***Passed by Consensus***).

4. PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP:

There were no comments.

5. COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP:

There was a request for minutes to be emailed sooner to allow more time for review. Mr. Land noted staff is working diligently and the Commission is trying to fill several vacancies.

6. CO-CHAIRS' REPORT: There was no report.

7. FY 2013 FINANCIAL EXPENDITURE REPORTS: This item was postponed.

8. FY 2014 PRIORITY- AND ALLOCATION-SETTING (P-AND-A): FY 2014 ALLOCATIONS MODIFICATIONS:

- Mr. Land noted the FY 2014 allocations memorandum. It details how the then Priorities and Planning (P&P) Committee developed allocations to guide DHSP while acknowledging that the rapidly changing economic and health care climate would necessitate review closer to the start of FY 2014.
- The process begins with the choice of paradigms which identify the perspectives from which the Commission approaches the P-and-A process and operating values which are the core principles that guide the process. For FY 2014, paradigms chosen were: compassion, equity and utilitarianism. Operating values were: access, efficiency and quality.
- Service category priority ranking is based solely on need for a service. A wide variety of information is used to determine priorities including consumer input and Los Angeles Coordinated HIV Needs Assessment (LACHNA) data.
- Mr. Vincent-Jones noted priorities normally stand for a year or two. These were done just six months ago and there is no reason to believe that they would have changed in that time. Medical Outpatient, e.g., is routinely ranked as the first priority. It does not matter whether the need is met by Ryan White, Medi-Cal or another health plan.
- Mr. Land noted the allocation process follows priority ranking. Decisions are based on priority rankings, the Service Utilization Report, LACHNA, other available streams of funding, cost and service effectiveness. Mr. Vincent-Jones said the primary purpose of this review is to make any needed allocation adjustments in lieu of the changing health care landscape.
- PP&A will need to revise its P-and-A process for FY 2015 to include prevention and STDs so in-depth review of the FY 2014 process is not needed. Core concerns are to review data presented at the last two PP&A meetings on service patterns and trends, how financial arrangements are working out and how to adjust allocations to accommodate an anticipated 10% cut.
- Ryan White award notification is not expected until February or March and there is no sequestration determination as yet. While a 14% cut was discussed previously, the estimate is now 10% or two years sequestration. The Federal budget passed. It modified this year's sequestration, but impact on appropriations is not known so more modifications may be needed.
- The purpose of modifications is to provide DHSP guidance on what contractual changes they might need to make.
- HRSA also modified its application. It made a mathematical error last year which affected the award. This year it cut hold harmless, but Mr. Vega-Matos said the County will support HIV services although the exact amount is not yet known.
- Mr. Vincent-Jones noted the County generally does well on its application. It was second last year.
- PP&A revised allocations at its meeting on 10/22/2013 for FY 2013 which ends 2/28/2014. Those revisions can be carried forward to FY 2014 if desired. They were: increase allocations for Medical Care Coordination (MCC) by 4.5% and Benefits Support by 0.5%; decrease allocations for Oral Health Care, 2.0%; Linkage To Care (LTC), 1.0%; Substance Abuse/Residential, 0.5%; Optometry, 1.0%; and Long-Term and Palliative Care, 0.5%.
- Mr. Johnson said this proves was much simpler when he first joined the Commission in 2007. The Committee reviewed such areas as unmet need and utilization, discussed options and completed the process without major issues. Changes began with the Seniors with Disabilities program, continued with the new 1115 Waiver and implementation of the Low-Income Health Program and now ACA. Consequently, data points the Committee previously had are no longer reliable.
- PP&A can only make the best decisions under the circumstances and revise them as needed until better data is available.
- Mr. Singer asked if the increase in Ambulatory Medical Outpatient (AOM) Fee-For-Service (FFS) costs are a dollar-for-dollar offset for the previously anticipated AOM savings from patients migrating to Medi-Cal and Covered California. Mr. Vincent-Jones replied it was not possible to determine that. This migration varies from that for LIHP because patients are migrating on a monthly basis that will likely evolve over a year. The category was not revised due to the uncertainty.
- Under medical outpatient cost reimbursement, DHSP negotiated a contract with each provider to serve its patients. The average of all contracts divided by patients served and visits was \$100 to \$150. The FFS rate per patient per visit is \$336. That will decline somewhat in the next couple of years based on quality performance, but the bottom rate is still \$285. The rate excludes laboratory expenses, imaging and medications not on the ADAP formulary which are all billed separately.
- Mr. Singer questioned the cost efficiency of the FFS rate since medical outpatient is the largest category. Mr. Vincent-Jones said that is not in the Commission's purview. It had acknowledged prior to the medical outpatient rate study that the cost reimbursement rate was too low to meet the standards of care. Whether the FFS rate is now too high is a matter for DHSP and the community to decide, but any revision will not come in time to impact allocations for FY 2014.
- Mr. Kelly recalled discussions on medical outpatient costs, but not that FFS could double costs. Ms. Jackson said AIDS Healthcare Foundation (AHF) had raised concerns with the Board, Health Deputies and the Commission that higher possible

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FFS costs could impact the system when it was already fragile due to other changes in the health care landscape. DHSP had said HRSA threatened to cut funding if FFS was not implemented, but AHF confirmed with HRSA that was inaccurate.

- Mr. Johnson noted ACA implementation offers the opportunity to see what Medi-Cal managed care and Covered California plans will spend on meeting the needs of PLWH. That information can inform future community FFS rate discussions.
- Mr. Vincent-Jones said the Commission has supported FFS for several years. Its implementation allows evaluating the financial complexity of a PLWH patient visit, not possible under cost reimbursement, and compare rates with other providers. The question of the rate is separate. PP&A can request more information on its composition.
- Mr. Vega-Matos said the process of transition to FFS started approximately 16 years ago. FFS introduces stability into the system. Previously, costs were uneven across providers. DHSP also wanted flexibility to allocate unspent dollars. In cost reimbursement, costs are allocated to the whole of service provision which varies among providers rather than costs for specific patients so expenditures may not be maximized. Other FFS services such as substance abuse can be evaluated.
- Mr. Vega-Matos urged recalling that a dollar does not buy the same services in 2014 that it did in 2005 whether in the Ryan White or other systems. Some Federally Qualified Health Center (FQHC) rates are as high or higher than Ryan White rates.
- Mr. Vincent-Jones noted the former Standards of Care Committee did not consider cost in determining its minimum standards. The new Standards and Best Practices Committee is beginning to address that issue.
- Mr. Vega-Matos said migration savings will develop over the year so will likely be higher in FY 2015. Providers are also paying stricter attention to eligibility. Cost reimbursement did not depend on entering patient data while FFS requires evaluating other payer sources. That, in turn, can lead to migration to other payer sources such as Medi-Cal. Some providers are also doing better at capturing patients eligible for the Ryan White system who were misclassified initially.
- Regarding eligibility, Mr. McMillin said many transitioning into standard Medi-Cal are no longer eligible for ADAP. He asked about recapturing such costs. Mr. Vincent-Jones noted ADAP enrollment accounts for just 0.5% under Medical Specialty.
- Mr. Johnson urged a broader view of the transition to a managed care. Many migrating to managed care plans will need Ryan White wrap-around services so the system will need to advocate for sufficient wrap-around funding and providers will need help to continue offering those services. He felt PP&A could be bold in cutting allocations for historical priorities to ensure sufficient wrap-around funding. Adjustments can always be made later based on service utilization data.
- Mr. Land suggested evaluating the impact of renewed Denti-Cal on allocations for oral health. FY 2013 allocations were revised to reflect a 2.0% decrease, but a deeper decrease to FY 2014 might be warranted. Mr. Vega-Matos said one proxy for how many patients might migrate to Denti-Cal is how many migrate to Medi-Cal, but that has not yet been projected.
- Mr. Johnson cautioned that Denti-Cal visits are being structured for the general population. Ryan White patients, however, typically need more extensive treatment so Ryan White will be needed to provide additional services. Mr. Vega-Matos added HRSA allows Ryan White to provide needed services not covered by a patient's insurance. There will be a discussion at the next Oral Health Advisory Committee on how to address services for PLWH in lieu of the new Denti-Cal.
- He continued that in FY 2013 some of the Phase II providers had not fully ramped up, but the remaining Phase II sites should be active by 3/1/2014. Mr. Vincent-Jones suggested that, in lieu of the Minority AIDS Initiative (MAI) allocation, the proposed FY 2014 Parts A/B 19% allocation could be reduced to 12% with the additional 2.0% from MAI. Mr. Vega-Matos was comfortable with that at this point since it has not yet been necessary to implement Phase III.
- Mr. Singer questioned the 6/13/2013 memorandum to the Commission which lists the FY 2013 allocation for Medical Outpatient/Specialty as 42.1%, the DHSP FY 2014 recommendation as 36.0% and the P&P proposal as 57.3%. Ms. Wu believed the 57.3% was a typographical error. The 7/11/2013 memorandum to the Commission lists 36.1%.
- Mr. Vega-Matos noted Medical Outpatient/Specialty also includes such categories as the Therapeutic Monitoring Program. Mr. Vincent-Jones added, while migration data is not yet available, total expenditures have been consistent with projections and allocations though expenditures in some of the eight subcategories were higher or lower. Based on that data, he suggested maintaining the allocation if possible until data is available that reflects lower utilization.
- Mr. Land noted some legislative discussion about covering the undocumented in Medi-Cal managed care. If that occurs, it would result in further migration from the Ryan White system. Mr. Vincent-Jones noted that would not impact FY 2014.
- Mr. Gutierrez said at the last meeting it was noted each category has a baseline allocation below which it is not viable. He suggested reviewing categories on the edge of viability and agreeing on whether to fund them.
- Mr. Ballesteros suggested review of FY 2013 revision decreases for application to FY 2014. Mr. Vincent-Jones added Long-Term and Palliative care expenditures are covered under residential services and Optometry remained unready to launch.
- Linkage To Care (LTC) was decreased by 1.0% since FY 2013 non-medical case management services were covered under Medical Care Coordination (MCC). MCC was increased by 4.5% to 18.6%. In FY 2014 those services will transition to LTC. Mr. Vega-Matos added two providers declined to continue services. MAI allocates 40% to LTC in FY 2014.

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- Regarding Home-Based Care, there was discussion about audits to assess reports that some long-term claimants returned to work, but remained enrolled. Mr. Singer noted many contracts were Medi-Cal Waiver so it could be a Medi-Cal audit.
- Mr. Vega-Matos said DHSP currently contracts \$3 million with six providers. The State directly funded approximately six community-based partners prior to Part B/SAM Care cuts. At that time, DHSP funded half of its current contracts. DHSP stepped in to prevent the collapse of the Home-Based Care program when the State defunded its community partners.
- All DHSP providers have a Medi-Cal Waiver contract. There are two kinds of patients. Those who do not qualify for other programs receive Home-Based Case Management, attendant and homemaker care. Services for those in the Medi-Cal Waiver program are capped, but Ryan White funds attendant and homemaker care once caps are exceeded. There are also some instances since the launch of MCC in which the medical home handles the case management piece.
- Like other contracts, DHSP audits programs annually. There have been instances, not across the board, in which a patient retained the service inappropriately. The provider is directed to dis-enroll the patient when that occurs.
- Mr. Vincent-Jones asked if there was an assessment of the Ryan White allocation impact. He felt that is a key question whenever Ryan White is supplemental funding for a service category with primary funding from another source. Since this is a FFS service, he urged collecting data to evaluate whether the 6.8% in funding is being spent strategically.
- Mr. Vega-Matos said DHSP can look into the service. It had begun to review providers before the State cut funding in 2009 and then the ACA transition diverted attention. DHSP wants to ensure the Medi-Cal Waiver cap is met before Ryan White funding is accessed, especially as most clients are Medi-Cal Waiver and do not show up in the Ryan White database.
- Mr. Ballesteros asked if more people will now be eligible for Medi-Cal. Mr. Vega-Matos did not know now, but expected that likely will be eligible. He recommended no cuts until the service is assessed as the current 6.8% funds existing contracts. Home-Based Care and Substance Abuse Services are FFS services so utilization can be evaluated.
- Mr. Vincent-Jones said reports should go beyond utilization and find a means to assess need. There is no way now to assess if Ryan White funds make a difference or its contribution is negligible. Mr. Vega-Matos noted Substance Abuse Services funds are negligible versus Substance Abuse Prevention and Control funds, but the real question is to assess unmet need. The two categories should be looked at both in the context of current contracts and systemically.
- Mr. Singer noted Medi-Cal Waiver eligibility criteria require that patients would need to be institutionalized without the service. Those criteria are stricter than those for Ryan White Home-Based Care so relatively few would qualify for both.
- Mr. Singer asked if there were categories not yet considered that could absorb a 1.5% cut to proposed FY 2014 allocations without impacting current contracts. He noted the 10% cut goal was estimated and 8.5% had been identified so further cuts might be delayed. Mr. Kelly asked about other categories with delayed contracts, e.g., due to lack of providers. Mr. Vega-Matos replied DHSP contracts to the level of allocations to the extent possible. There were no other categories such as Optometry where contracting has been delayed. He could not determine if all allocations will be maximized at this point.
- Mr. Land suggested decreasing Substance Abuse/Residential by 0.5% consistent with the FY 2013 revision due to underspending. Mr. Vega-Matos wanted more data before supporting a FY 2014 reduction. He noted DHSP funds detox and residential treatment which are core medical services and transitional which is a support service.
- Ms. Forrest was concerned that substance abuse services are key for prevention and treatment. Not all providers for PLWH are part of ACA plan networks. Mr. Vega-Matos noted Ryan White cannot cover insured services so providers should join.
- Mr. Singer asked if Local Pharmacy Program/Drug Reimbursement (LPP/DR) was a safety net that was not implemented. Mr. Vega-Matos said just a subset of AOM providers under cost reimbursement had allocations to help with medications not covered by ADAP. Under FFS, all AOM providers received such allocations so there will be data by year's end on how many providers have accessed the funds which are tied to Ryan White eligibility. Ms. Wu added HRSA has determined that LPP/DR does not qualify as a local pharmacy drug assistance program so it must be reported under AOM.
- Mr. Vincent-Jones noted allocations or modifications are generally made in June for the next year, at the end of the current year and when the award is received, but can be made at any time. Expenditure reports are designed to inform PP&A on needed modifications. Mr. Singer asked if these proposals are for actual cuts. Mr. Vincent-Jones replied the discussion baseline is proposed FY 2014 allocations. Discussions could develop a new baseline or a 10% cut scenario.
- Ms. Tula felt mental health funding was insufficient. She did not advocate for a higher allocation, but asked how Ryan White and Department of Mental Health (DMH) funding interacts. Mr. Vega-Matos said Ryan White pays for services not covered by other sources such as Medicaid and Medi-Medi. Many patients may be eligible for services under Medi-Cal but, for example, visits may be capped at eight for a patient who needs 12. Ryan White would pay for the other visits.
- Patients with FQHCs generally need to meet DMH criteria for severe, persistent and incapacitating conditions. DMH directly contracts services for the severely mentally ill.

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- Mr. Vega-Matos noted many in the Ryan White system have mild to moderate mental illness so do not qualify for direct DMH services. Behavioral health is covered by Medicaid expansion and Covered California, but coverage is not yet known. In theory, covered patients should be able to access services either through their health plans or through DMH.
- It was suggested that knowing migration numbers to Covered California and baseline network mental health benefits for those plans could inform mental health allocations. Mr. Singer stressed it would be unethical to disrupt continuity of mental health care for those receiving Ryan White services now. Covered California infrastructure is not fully in place with many providers still trying to contract with networks, learning how to access their services and how to bill.
- Over time, allocations can likely be reduced. Since most Ryan White clients are mild to moderate, migrating clients will be able to access services through Medi-Cal or Covered California. Currently, migration numbers are in flux. Covered California benefits, in particular, are unclear and questions remain about their providers and provider expertise with PLWH.
- Mr. Land asked if the Commission can request DMH reimbursement to the Ryan White social service system for services it should have been providing to PLWH. Mr. Singer noted DMH will not be covering most services provided by Ryan White. Mr. Vincent-Jones said, though he was unfamiliar with all details of the situation, DMH was supposed to absorb costs for a number of Ryan White clients, but had not. He felt it appropriate to ask a key partner to meet its obligations.
- Mr. Vincent-Jones noted the proposed FY 2014 allocation of 2.0% for the Local Pharmacy Program/Drug Reimbursement has been shifted to Medical Outpatient/Specialty (MO/S). He was uncertain why the FY 2013 allocation for Medication Assistance and Access including LPP/DR (3.5%) and ADAP/ADAP Enrollment (1.0) was decreased from 4.5% to 2.0%.
- He also did not recall a specific discussion on reducing MO/S from 42.1% to 36.1%, but there were some projections of savings due to migration which do not now appear accurate. Current expenditures appear flat so, including the incorporation of 2.0% from LPP/DR, there remains a gap of 4.0% that needs to be addressed.
- Mr. Vega-Matos reported contracts for MCC Medical Case Management total \$8.6 million while contracts for Non-Medical Case Management, being transitioned from MCC to LTC, total \$1.1 million. Mr. Singer noted, at \$350,000 per 1.0%, that is nearly 28.0%. Dave Young, Chief, Financial Services, will attend the 1/28/2014 PP&A meeting with additional financial data.
- Directive: DHSP will provide a report on the structure of AOM FFS and the composition of its rate within six months.
- Directive: DHSP will provide a report on Home-Based Care and Substance Abuse Services within six months.
- Directive: Mr. Vincent-Jones and DHSP will develop a communication to DMH regarding the DMH role in the ACA-Ryan White equation and querying why funds for services that DMH should be providing to PLWH have not been made available.
- Directive: DHSP and the Commission will develop an inventory of all mental health services including information on the new RFP being written to reflect the revised standards of care.
- Confirmed that the accurate FY 2014 Medical Outpatient/Specialty proposed allocation was 36.1%.
- Continue decreases from revised FY 2013 to proposed FY 2014 allocations as follows: Substance Abuse/Residential, 0.5% from 4.6% to 4.1%; Optometry, 1% from 1.0% to 0.0%; and Long-Term and Palliative Care, 0.5% from 0.5% to 0.0%.
- Re-allocate 1.5% from MCC to LTC to accommodate contracts transitioning from MCC to LTC.
- Decrease proposed FY 2014 Oral Health Care allocation from 19.0% to 12.0% in consideration of an additional 2.0% in MAI allocations and the continued postponement of the Phase III expansion.
- Decrease proposed FY 2014 Medical Outpatient/Specialty 1.0% from 36.1% to 35.1%.
- Mr. Vincent-Jones will provide a revised Part A/B allocations table with columns for revisions made to the FY 2013 allocations and revisions made during this meeting to the proposed FY 2014 allocations.
- The 1/28/2014 meeting will specifically address the apparent 4.0% gap for the proposed FY 2014 MO/S allocation and the apparent gap in funding for MCC.

A. Assessing Impact of ACA Implementation:

- Mr. Ballesteros said migration will mostly be into Medi-Cal but, to a lesser extent, Covered California as well. Those plans primarily cover core medical services with some laboratory costs and some substance abuse treatment. Many Ryan White patients moving into ACA plans will continue to need various wrap-around services.
- Meanwhile, a significant number of patients will remain in Ryan White and continue to need the full range of services.
- It is important to assess maximizing the various funding streams including ACA and Ryan White. Ms. Enfield felt there was insufficient ACA data to assess its impact. Mr. Land replied PP&A commonly lacks all the data it would prefer to make such decisions, but must provide the best possible guidance for DHSP to manage its provider contracts.
- Mr. Vega-Matos noted DHSP has several funding cycles with different contracts on different budget terms. The first Ryan White contracts have terms starting March 1st with others starting April 1st and some July 1st.
- Mr. Vincent-Jones said approximately 4,000 people moved into Medi-Cal under ACA Medicaid expansion. Savings were expected because Ryan White will no longer have to pay for their medical outpatient. However, Dave Young, Chief,

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Financial Services Division, DHSP, reported at the last PP&A meeting that the new FFS rate per patient per visit is considerably higher than the prior cost reimbursement system so it will cost more for remaining patients.

- Mr. Vega-Matos added migration for both Medi-Cal and Covered California will take place over a year so final estimates of migrating patients will not be available March 1st. Mr. Vincent-Jones said 1,500 Ryan White patients are estimated to be eligible for Covered California. Some of those may choose to accept the tax penalty rather than migrate.

B. Contingency Funding Scenarios: This item was postponed.

C. Resource Allocations: This item was postponed.

9. FY 2014 WORK PLAN: This item was postponed.

10. NEXT STEPS: There was no additional discussion.

11. ANNOUNCEMENTS: There were no announcements.

12. ADJOURNMENT: The meeting adjourned at 4:00 pm.